DOCUMENT RESUME

ED 181 303 CE 023 886

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TITLE Occupational Role Innovation and Secondary Career Choice among Women Medical Students.
INSTITUTION Emory Univ., Atlanta, Ga.
SPONS AGENCY National Center for Health Services Research (DHEW/PHS), Hyattsville, Md.
PUB DATE Aug 79
GRANT HS01924
NOTE 20p.; Paper presented at the Annual Meeting of the American Sociological Association (Boston, MA, August, 1979).

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Career Choice; Changing Attitudes; *Females; *Medical Students; *Nontraditional Occupations; *Physicians; Sex Stereotypes; *Specialization; Surveys; Working Women

ABSTRACT

Although all women medical students have demonstrated occupational role innovation by their career choice, their selection of the field in which they will specialize during their medical careers (secondary career choice) may or may not represent additional innovation. Women enrolled in two medical schools in 1975-76 who stated that they had made a speciality decision were classified as either "Traditionals," if they chose a specialty in which women are disproportionately represented, or as "Pioneers," if they chose a specialty in which men are disproportionately represented; those who chose specialties having similar percentages of women and men formed a third group. Results from this study, and data from other recent studies, indicate decreased choice of Traditional specialties and increased choice of Pioneer specialties, especially by more recent entrants of medical school. As compared to women making Traditional choices, Pioneers were more willing to work in areas where women are not fully accepted and to devote extensive time to their medical practice. (Author/BM)

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OCCUPATIONAL ROLE INNOVATION AND SECONDARY CAREER CHOICE AMONG WOMEN MEDICAL STUDENTS*

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*Paper presented at the annual meeting of the American Sociological Association, Boston, August, 1979.

Author's Note: This research was supported by Grant HS01924 from the National Center for Health Services Research. The authors wish to acknowledge Heather Gray for interviewing assistance and Michael Kutner for assistance in data analysis.

CE023886

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OCCUPATIONAL ROLE INNOVATION AND SECONDARY CAREER CHOICE AMONG WOMEN MEDICAL STUDENTS

Abstract

Although all women medical students have demonstrated occupational role innovation by their career choice, their selection of the field in which they will specialize during their medical careers (secondary career choice) may or may not represent additional innovation. Women enrolled in two medical schools in 1975-76 who stated that they had made a specialty decision were classified as Traditionals if they chose a specialty in which women are disproportionately represented and as Pioneers if they chose a specialty in which men are disproportionately represented; those who chose specialties having similar percentages of women and men formed a third group. Our data, and data from other recent studies, indicate decreased choice of Traditional specialties and increased choice of Pioneer specialties, especially by more recent entrants to medical school. As compared to women making Traditional choices, Pioneers were more willing to work in areas where women are not fully accepted and to devote extensive time to their medical practice.

OCCUPATIONAL ROLE INNOVATION

The term "occupational role innovation" has been used to refer to a non-sextypical occupational choice (Tangri, 1972; Rosen, 1974). Although the concept applies equally to the movement of men into stereotypically female occupations (e.g. nursing) and to the movement of women into stereotypically male occupations (e.g. medicine), the latter phenomenon is of particular interest because the "sex-map of the occupational world" (Bird, 1968) offers fewer approved choices for women than for men. Because the profession of medicine continues to be dominated by men (8.3% of the physicians active in the U.S. in 1976 were women), women medical students can be classified as occupational role innovators.

Women medical students' selection of the field in which they will specialize during their medical careers may indicate additional innovation; in other cases, however, it may represent "a strategy to minimize deviance by becoming less visible" (Quadagno, 1976, p.451). Such secondary choices within careers, especially among women, have received less attention than has initial choice of occupation (Back, Coker, & Donnelly, 1958). Rosen (1974, p.554) notes that the concept of occupational role innovator "has been defined narrowly, with no implications concerning the style of role enactment..." In this paper we explore "styles" of occupational role innovation represented by the secondary career choices of women medical students.

Women physicians are disproportionately represented in some specialties of medicine--particularly pediatrics, psychiatry, and public health--and underrepresented in others, especially the surgery specialties. Discussions of reasons for the specialization distribution of female physicians have tended to emphasize the practice patterns associated with particular specialties. Kosa and Coker (1965) reported that women were attracted to the field of public health because of the stable work-hours, "liberation from the entrepreneurial role," and opportunity for part-time employment which characterize this area of medicine. Similarly, Knight (1973) states that some specialties, in addition to allowing choice of work-hours, shield women physicians from a possibly prejudiced public and are chosen for this reason as well; he cites the fields of radiology, pathology, and anesthesiology as examples. However, the practice pattern

"explanation" of specialty choice by women does not satisfactorily account for the very small numbers of women physicians in opthalmology, otolaryngology, plastic surgery, and dermatology--all of which would have ideal work-hours for a woman physician with a family (Epstein, 1971). Nor does this explanation satisfactorily account for the number of women pediatricians who are solo practitioners or the number of women who select child psychiatry, which has a long residency.

It is likely that a more important reason for women's concentration in areas such as public health, psychiatry, and pediatrics is the relatively lower prestige and income associated with these fields (Merton, Bloom, & Rogoff, 1956; Back, Coker, & Donnelly, 1958; Jeffers, 1967; Zimet & Held, 1975). The latter explanation for women's concentration in pediatrics and psychiatry (especially child psychiatry) may also be more important than the alleged "natural" ability of female physicians to relate to children and to be sensitive to others' problems. The fields of obstetrics and gynecology could just as easily be viewed as "naturals" for women, but a relatively small number (6.5%) of women physicians are in these fields. Quadagno's (1976) interviews with 28 practicing women physicians included no instances of women indicating that their specialty choice stemmed from a desire to carry out female roles such as mothering in pediatrics or nurturing in psychiatry, although these motivations were attributed to women by several male physicians whom she interviewed and by male physicians interviewed in another study at an eastern medical school (Ducker, 1978).

It has recently been suggested that an increased number and variety of women in medical school, along with a social climate which makes it more acceptable for women to seek careers in areas other than those traditionally viewed as open to women, will operate to produce shifts in traditional medical specialty choice patterns among women (McGrath & Zimet, 1977). However, Quadagno (1976) found more evidence of sex-stereotyping of specialties among younger physicians than among older physicians, which led her to suggest that the field of medicine may become increasingly sex-segregated, with an intensification of female labor in certain specialties such as pediatrics and psychiatry which will eventually make them "female occupations."

Although an extensive body of literature exists about factors related to male medical students' choice of specialties (University of New Mexico,

1974), women medical students have not been included in these analyses because there have been so few of them. Thus, little is known about the correlates of specialty choice among women. Our study addresses an area of growing importance as the proportion of women entering medicine increases[1]--an area which has implications also for the persistence of occupational segregation within the medical profession.

METHOD

Subjects. This research is part of a larger study of women medical students' careers. An effort was made to contact all women who were enrolled during academic year 1975-76 in the two medical schools in a southern state, one private school and one state-supported school. The latter school draws almost all of its students from in-state, while the private medical school is more expensive and has a more geographically diversified student body. Cooperation was obtained from 97% of the women students at the private school (N=71) and from 90% of the women students at the state school (N=98).[2]

Our analysis focuses primarily on 54 women students who stated that they had decided what medical specialty they would enter. Specialty decision or choice is a more critical variable than specialty interests, which are often the focus of studies of medical students (Weinstein & Gipple, 1975; Zimet & Held, 1975; McGrath & Zimet, 1977). For example, Matteson and Smith (1977) recently found that 25% of their sample of students at a southwestern medical school expected to enter a specialty other than the one they most preferred.

Procedure. Personal interviews were conducted by the first author or a research assistant with the majority of subjects, and 38 women at the state school completed a self-administered questionnaire adapted from the structured interview schedule.[3] In addition to exploring specialty preferences and decisions, the data-collection instruments included questions about the decision to enter medicine (Kutner & Brogan, in press), problems encountered in medical school, and practice pattern preferences (Kutner & Brogan, 1979).

To enable us to compare our data with the current distribution of

women physicians across various medical specialties, Table 1 was constructed from data contained in the 1976 American Medical Association physician master file. Table 1 shows that the percentage of women physicians significantly exceeds the percentage of men physicians in pediatrics, public health, anesthesiology, psychiatry, and pathology. On the other hand, with the exception of obstetrics-gynecology, the percentage of men in the various surgical specialties is in most cases twice or more as great as the percentage of women in those same specialties. Internal medicine, obstetrics-gynecology, dermatology, and neurology are fields which do show similar percentages of women and men physicians. This overview of the current specialty distribution of women and men physicians suggests that specialties of medicine can be grouped into three categories: those entered disproportionately by women, those entered disproportionately by men, and those which women and men are equally likely to enter.

(Table 1 about here)

Following the Traditional/Pioneer typology of Nagely (1971), women medical students who stated that they had decided on a specialty were classified as Traditionals if their choice was a specialty in which the percentage of women physicians significantly exceeded in 1976 the percentage of men physicians.[4] Women medical students were classified as Pioneers if their choice was a specialty in which the percentage of men physicians significantly exceeded in 1976 the percentage of women physicians.[5] The third group includes women medical students who chose a specialty which in 1976 had almost equal percentages of women physicians and men physicians;[6] for lack of a better term, we refer to these women as the Equal Representation group.

As noted in Table 1, the American Academy of General Practice officially changed its name in 1969 to the American Academy of Family Physicians. This specialty grouping, therefore, includes both "general practitioners" (non-board-certified) and family practitioners (board-certified in family medicine). Because this specialty grouping has thus far been entered disproportionately by men, we categorize family practice as a Pioneer specialty. Research (Zimet & Held, 1975) indicates that family practice tends to be viewed as a relatively low status specialty (a view which was characteristic also of students at the two medical schools in our study), and women

in medicine, as in other occupations, tend to occupy lower status positions than do men. On the other hand, the demands associated with a family medicine practice, especially in a rural area, may easily deter women from choosing this specialty. At one of the medical schools in our study there was no family medicine department and virtually no institutional support for students' choice of family medicine as a specialty. Family practice is a relatively new field, and attitudes toward it vary within the medical profession (Farley, 1976; Sundwall, 1977). Recent studies have shown considerable variation in its popularity among women medical students; only 9% of the women surveyed in 1976 at a southwestern medical school named family practice as their first preference (Matteson & Smith, 1977, p.550), while 44% of the women surveyed in 1974-75 at two western medical schools named family practice as their first choice (McGrath & Zimet, 1977, p.295). Although family practitioners, like pediatricians, may be viewed as "warm," "person-oriented," and "concerned" (Zimet & Held, 1975, p.165), we believe that family practice, at least at this point in time, should be categorized as a Pioneer specialty for women.

RESULTS

Types of Secondary Career Choice among Women Medical Students. The 54 women who had made a definite specialty choice were almost equally likely to have selected a Traditional (35.2%), Pioneer (31.5%), or Equal Representation (32.3%) field (Table 2). This distribution differs significantly [$\chi^2(2)=8.39$, $p<.02$] from the specialty distribution which characterized active women physicians in the U.S. as of 1976--49.9% of whom were in Traditional specialties, 17.5% of whom were in Pioneer specialties, and 32.6% of whom were in Equal Representation specialties.

(Table 2 about here)

Recognizing that the 54 deciders may have represented an unusual group of women students at the two medical schools studied, specialty interests of the remaining 113 women subjects[7] were examined. Again, interest in Pioneer specialties was higher than the current specialty distribution of female physicians would predict: 70% of the non-deciders expressed interest in at least one Pioneer specialty, and 38% of the non-deciders were most interested in a Pioneer specialty.

Correlates of Secondary Career Choice among Women Medical Students. Women choosing Traditional, Pioneer, and Equal Representation specialties differed significantly with respect to the medical school in which they were enrolled [$\chi^2(2)=11.20$, $p<.003$] and their medical class status [$\chi^2(2)=8.37$, $p<.03$]. Women who had made Pioneer specialty choices were significantly more likely to be enrolled in the private medical school than the state medical school (Table 3) and to be first- or second-year students as opposed to third- or fourth-year students (Table 4).

(Tables 3 and 4 about here)

No explanation of the medical school difference was readily apparent. The state medical school draws almost all of its students from in-state, while the private medical school has a more geographically diversified student body. However, women who had made a Pioneer specialty choice did not differ in geographical background from those who had made a Traditional choice. In addition, the investigators could not identify differences in institutional sources of support at the two schools for women's choice of a career in Pioneer fields such as surgery or family practice. Moreover, among the 113 women who had not yet decided on a specialty, those who were most interested in a Pioneer specialty were just as likely to be enrolled in the state school as in the private school.

As was true for women who had decided on a specialty, there were more first- and second-year non-deciders (43%) than third- and fourth-year non-deciders (22%) who were most interested in having a career in a Pioneer specialty. This suggests that the popularity of the Pioneer specialties may be greater among more recent entrants to medical school. Although we do not know whether the specialty choices of first-year students will remain stable until their graduation from medical school, examination of the internship appointments of subjects who were in their second, third, and fourth years of medical school at the time of our study indicates that our subjects did in fact enter the fields they said they intended to enter.

There was some evidence that women making Pioneer choices were more likely than the other two types of women to be involved in groups such as N.O.W. or a support group for women medical students [$\chi^2(2)=4.38$, $p=.13$]. Women who joined a support group may have done so for some of the same reasons that led them to make a Pioneer choice, or they may have joined such

a group in order to seek support for their non-traditional choices.

No relationship was found between type of specialty choice and subjects' birth order, marital status, mother's or father's education, mother's or father's occupation, southern vs. non-southern background, or sex-role attitudes as measured by our sex-role orientation scale (Brogan & Kutner, 1976). Nor was a relationship found between type of specialty choice and faculty or peer influences on the specialty decision.

Motivations for Secondary Career Decisions among Women Medical Students. As reasons for their specialty choice, almost all subjects cited the interesting aspects of their chosen field and/or the type of patients with whom they would be able to work, e.g. children (pediatrics) or "whole families" (family practice). However, the intellectual stimulation and variety of their chosen fields were most emphasized by the Pioneer and Equal Representation groups.

With the exception of one Pioneer who had selected ear-nose-throat surgery for her career, only women in the Traditional group mentioned practice pattern considerations as reasons for their specialty choice, e.g. flexible work-hours, short-term patient responsibility, lack of physical strain. These considerations had most influenced women who selected anesthesiology, psychiatry, or public health; as Epstein (1971) pointed out, a favorable practice pattern is generally not associated with a career in pediatrics.

Thus, relatively little support was provided by our data for a practice pattern explanation of women's specialty choice; practice considerations were important only for women who chose Traditional specialties. Nor was there support for Knight's (1973) allegation that women physicians may desire to avoid a potentially prejudiced public. Two women acknowledged their dislike for primary care involving direct patient contact and had selected careers in pathology (Traditional) and neurological research (Equal Representation); this was a personality preference, however, rather than a fear of encountering prejudice. The only woman who cited the special qualities which a woman can bring to medicine had chosen gynecology and obstetrics (Equal Representation) for her career.

Women in all three categories shared the belief that it is easier for a woman physician to practice in some specialties than in others. Anesthesiology was described as a field free of "sex-bias." Pediatrics was selected by one woman because it is a field with "lots of women"--one in

which she would feel no pressure to "constantly prove herself and assert herself as a woman." Two women who had been torn between Equal Representation specialties and a Pioneer field, surgery, decided against the latter because of a number of strains they perceived as inherent for women in surgery, including a lack of acceptance of women. Women in the Pioneer category who had selected surgery or a surgery subspecialty acknowledged having encountered discouragements, both subtle and direct, from "just about everyone."

An indication that the specialty choice process was more difficult for Pioneers than for the other two groups of women was the fact that 94.1% of the Pioneers had seriously considered entering other specialties, as compared to 63.2% of the Traditionals and 66.7% of the Equal Representation group. The types of specialties seriously considered but rejected by subjects in each of the three groups are indicated in Table 5. It is interesting that half of the women making Traditional choices who had seriously considered other specialties had been attracted to Pioneer fields: family practice, cardiology, and surgery. Two other women who had made Traditional choices had been very interested in surgery, but did not consider entering it because of its inherent time-demands.

(Table 5 about here)

SUMMARY AND DISCUSSION

The existence of internal sex-typing within the medical profession has been noted by several observers over the past ten years (Lopate, 1968; Epstein, 1971; Quadagno, 1976; Matteson & Smith, 1977). Quadagno (1976,p.452) predicts an increase in sex-segregation by specialty within medicine, citing "the past history of labor market trends indicating continual sex-typing and the presence of the stereotyping of specialties among younger even more than older physicians." McGrath and Zimet (1977), on the other hand, believe that the growing number of women medical students will frequently make specialty choices which depart from the fields which women have traditionally entered. These differing predictions stem from different premises, one which relates to the medical profession and one which relates to the larger society. Quadagno stresses the restrictions on women medical students' specialty choice, i.e. explicit rejection from the field of surgery and lack of en-

couragement from faculty except those in the traditional female areas, while McGrath and Zimet (1977, p.299) cite "the effect of the 'women's liberation' movement and the consequent changes in the social climate making it more acceptable for women to seek a career in specialties other than those traditionally viewed as open to females."

Quadagno (1976, p.450) does not report the specialties in which her sample of 28 women physicians were practicing, stating only that "their awareness of negative attitudes toward them in certain areas combined with positive reinforcement in others led them to avoid situations where conflict might occur. Rather than confront possible rejection, women selected specialties in which they felt comfortable and welcome." The impression is given that this group of women physicians, two-thirds of whom were age 35 or older, had overwhelmingly opted for specialties considered traditional for women. In contrast, among the 95 women students in two western medical schools surveyed by McGrath and Zimet in 1974-75, 48% were most interested in a Pioneer specialty (family practice or surgery). Our own data, as well as the recent study of Matteson and Smith (1977)[8], suggest that not this many women will actually choose a Pioneer specialty, but it does appear that women medical students of the 1970's are increasingly being attracted to fields other than those which women have traditionally entered. These data lend support to Knight's (1973, p.189) assertion that "...the changes in society involving women will surely influence their life and work in medical school and in the practice of medicine..."

Women in our sample who had made Pioneer choices were more likely to be recent entrants to medical school than were their same-sex peers who had made other types of specialty choices. It can be argued that the greater frequency of Pioneer choices among younger entrants may have reflected the fact that these students had not yet been socialized into traditional patterns. However, two-thirds of the first- and second-year women who said they had definitely decided on a specialty had made this decision before they entered medical school and therefore were unlikely to change their minds; previous research has shown that "a substantial degree of specialty choice has already taken place at the time of entrance to medical school..." (Schroeder & Schliftman, 1973, p.343). In addition, 6 of the 9 first- and second-year women who had made Pioneer choices were planning to enter family prac-

tice and were going to fulfill "country doctor" loan obligations by practicing in small communities after completing their training.

Women who had made Pioneer choices were more likely to be students at the private medical school than the state medical school. Although our data on preferred specialty of women who had not yet made their specialty decision did not indicate differences by medical school, we recognize that the climate of a particular medical school can potentially have an important impact on students' specialty choices.

The selection of a medical specialty has been termed "one of the most stressful decisions of medical school" (McGrath & Zimet, 1977, p.294). Among our sample of women medical students who had made a specialty decision, almost all of the women making a Pioneer choice had seriously considered entering a specialty other than the one they finally selected. These women were more likely to have considered Traditional or Equal Representation specialties than other Pioneer specialties. Of the 19 women who had made a Traditional choice, 8 had been strongly attracted to a Pioneer field. Thus, a number of the women making Pioneer and Traditional choices had been attracted to both types of specialties. The innovation represented by a Pioneer choice seemed to indicate willingness to work in an area where women are not fully accepted (especially for those who chose surgical areas) and/or willingness to devote extensive time to future medical training and practice. Since Pioneer women were just as likely as women choosing other types of specialties to be married and/or planning to have a family, perhaps (as suggested by Nagely, 1971) Pioneers are women who are especially adept at integrating the roles of homemaker and worker.

Regardless of the field of medicine in which they decide to specialize, women who undertake careers in medicine are occupational role innovators. Even if they decide to practice pediatrics, the specialty which currently has the highest representation of women physicians, fewer than one of their four colleagues will also be a woman. However, our data suggest that recent women entrants to medical school may be less likely to "minimize deviance" by choosing traditionally female specialties, indicating a trend among women toward increased occupational role innovation in choice of secondary, as well as primary, medical careers.

Addendum

With the graduation in June, 1979, of the first-year medical students who participated in this research, information was available to the authors on internship placements of all four classes of students. Our examination of this information indicates that:

(1) Internships in the three types of specialties (Traditional, Pioneer, Equal Representation) did not differ for women at the two medical schools.

(2) The percentage of women in the 1979 graduating class who took internships in Pioneer specialties is not significantly higher than the corresponding percentages of women in the 1978, 1977, and 1976 classes--although it is somewhat higher. However, the percentage of women who took internships in Traditional specialties was significantly lower than the percentage of active women physicians in the U.S. who were in Traditional specialties as of 1976; this was true for women in all four graduating classes.

(3) Of the 17 women who, at the time of the study, said they had decided to enter a Pioneer specialty, 10 actually entered consistent internships; four women took internships in Traditional specialties, and two women took internships in an Equal Representation specialty which would still allow them to eventually enter a Pioneer specialty (Family Practice). The one remaining subject was not listed as a graduate with her class.

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NOTES

1. There has been a dramatic increase since 1970 in the number of women entering medicine; women represented 9.0% of all medical students in 1970 but 22.4% of all medical students in 1977 (Undergraduate medical education, 1977:2771).

2. Repeated efforts were made to obtain the cooperation of the remaining 13 women students enrolled during 1975-76 at the two schools. Only two women actually refused to participate by communicating this to the first author. Two women agreed to be interviewed but failed to keep the appointment and also failed to respond to follow-up communications. The other nine women simply failed to respond to repeated written communications and could not be reached by telephone.

3. Of these women, 36 were first-year students at the state school who were contacted in a classroom situation; the remaining two women were upperclassmen whose clinical schedules did not permit time for a personal interview.

4. Pediatrics, anesthesiology, pathology, psychiatry, physical medicine, preventive medicine, public health.

5. Family practice, cardiovascular disease, gastroenterology, general surgery, opthalmology, orthopedic surgery, plastic surgery, other surgery, occupational medicine.

6. Allergy, dermatology, internal medicine, pulmonary disease, obstetrics/gynecology, neurology, radiology, other.

7. Two women refused to commit themselves to any particular specialty interests.

8. Among 64 women students enrolled in a southwestern medical school in 1976, Matteson and Smith (1977) found 21.6% believing they were most likely to enter a Pioneer specialty (family practice or surgery), 54.8% believing they were most likely to enter an Equal Representation specialty (internal medicine or obstetrics/gynecology), and 23.6% believing they were most likely to enter a Traditional specialty (pediatrics or psychiatry).

TABLE 1

Distribution of Women and Men Physicians

by Specialty, 1976

	Women[1] (N=28,966)	Men[1] (N=319,47?)
General Practice[2]	10.9%	16.4%
Medical Specialties	37.6%	27.7%
Allergy	.4	.5
Cardiovascular diseases	.6	2.1
Dermatology	1.4	1.4
Gastroenterology	.2	.7
Internal medicine	15.5	16.7
Pediatrics[3]	18.9	5.6
Pulmonary diseases	.6	.6
Surgical Specialties	11.6%	29.8%
General surgery	2.6	9.9
Obstetrics-gynecology	6.5	6.4
Opthalmology	1.5	3.4
Orthopedic surgery	.2	3.7
Otolaryngology	.3	1.8
Plastic surgery	.2	.7
Other surgery[4]	.2	3.9
Other Specialties	39.9%	26.1%
Anesthesiology	6.3	3.6
Child psychiatry	2.3	.6
Neurology	1.3	1.3
Occupational medicine	.3	.7
Pathology[5]	6.0	3.2
Psychiatry	11.6	6.6
Physical medicine	1.1	.4
Preventive medicine	.4	.2
Public health	1.8	.6
Radiology[6]	3.8	4.9
Other[7]	2.2	2.4
Unspecified	2.6	1.5

1 Active physicians as of December 31, 1976, whose address was known to the American Medical Association and for whom specific information was available; physicians having a temporary foreign address are excluded. The data on which this table is based were taken from Louis J. Goodman, Physician Distribution and Medical Licensure in the U.S., 1976, published by the A.M.A. in 1977.

2 Although the American Medical Association continues to use the designation General Practice when reporting physician specialty distribution, in 1969 the American Academy of General Practice officially changed its name to the American Academy of Family Physicians.

3 Includes pediatric allergy and pediatric cardiology.

4 Includes neurosurgery, colon and rectal surgery, thoracic surgery, and urology.

5 Includes forensic pathology.

6 Includes diagnostic radiology and therapeutic radiology.

7 Includes specialties such as aerospace medicine and nuclear medicine.

TABLE 2

Specialty Choices of 54 Women Medical Students
in Two Southern Medical Schools, 1975-76

Traditional Specialties		Pioneer Specialties		Equal Representation Specialties	
Pediatrics	5	Family practice	10	Dermatology	1
Anesthesiology	5	General surgery	2	Internal medicine	8
Pathology	1	Opthalmology	1	Obstetrics-gynecology	3
Psychiatry	7	Orthopedic surgery	1	Neurology	3
Public health	1	Otolaryngology	1	Radiology	1
		Other surgery	2	Research	2[a]
Total	19	Total	17	Total	18

a These two women planned to work in neurology (research entered by 0.1% of both women physicians and men physicians) and in oncology, a subspecialty of internal medicine (internal medicine research accounts for 0.8% of women physicians and 0.7% of men physicians).

TABLE 3

Percentage Distribution of Women Students
by Type of Specialty Choice and Medical School

	Specialty Choice		
Medical School	Traditional (N=19)	Pioneer (N=17)	Equal Representation (N=18)
Private school	16	59	39
State school	84	41	61
Total percent	100	100	100

TABLE 4

Percentage Distribution of Women Students
by Type of Specialty Choice and Year in Medical School

Year in medical school	Specialty Choice: Traditional (N=19)	Pioneer (N=17)	Equal Representation (N=18)
First or second year[1]	21	53	11
Third or fourth year[2]	79	47	89
Total percent	100	100	100

1 Often referred to as "the basic science years"; students spend the majority of their time in the classroom, completing required courses.

2 Often referred to as "the clinical years"; students spend time in actual patient care while rotating through various medical school departments.

TABLE 5

Frequency Distribution of Women Students' Mentions[1]
of Other Specialties Which They Had Seriously Considered Entering

Other specialties considered	Specialty Choice: Traditional	Pioneer	Equal Representation
Traditional	1.17	6.17	4.42
Pioneer	6.00	4.50	3.00
Equal Representation	4.83	5.33	4.58
Total number of students who considered other specialties	12.00	16.00	12.00

1 Mentions by a student of more than one type of specialty were allocated proportionally to the appropriate categories.